BlueCross BlueShield of Texas

Instructions for Completing
Standard Authorization Form
To Complete Form go to Page 4 of 5

Use this form to authorize Blue Cross Blue Shield of Texas to disclose your protected health information (PHI) to a specific person or entity. You may follow the instructions we provided below or you may call the Customer Service number listed on the back of your Membership Identification card for assistance in completing the form. You must complete all the fields on this form.

Please remember:

- One **authorization form** can be used for a range of and/or multiple services or providers.
- **Authorization** forms can be completed claim by claim, procedure by procedure, or for services within specified timeframes.
- The **individual**'s use of the **authorization form** is always voluntary.

I. Individual (Name and information of person whose protected health information is being disclosed):

Field	Value
Name	Jane Doe
Date of Birth	05-10-1962
Group #	123456
Identification/Subscriber #	XOP123456789
Social Security Number	###-##-####
Address	123 Main Street
City	Anytown
State	TX
ZIP	12345
Area Code & Telephone Number	312-555-1212

All of the information in **Section I** pertains to the individual for whom the authorization is being requested. The individual may be the subscriber, his or her spouse, a dependent or any other **individual** covered or applying for coverage under the subscriber's membership. All fields in this section are **required**. In this example, Jane Doe is the individual for whom the authorization is being requested.

II. Authorization and Purpose:

I request and authorize Blue Cross and Blue Shield of Texas to disclose my protected health information as described below. **I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.**

Field	Value
Persons/Organizations authorized to receive your information	Suzy Smith
Relationship	Daughter
Purpose	Assisting in medical care
Address	456 Mill Road
City	Happytown
State	TX
ZIP	45678

Section II identifies the person/entity that will be receiving the PHI about the individual identified in Section I. An individual could authorize disclosure of his or her PHI to a close friend, a broker, an attorney, or a specific member of his or her employer's benefits staff. The individual may also authorize disclosure to an organization. Include the information identifying the organization's job titles to receive the PHI (e.g., Benefits Representatives, Human Resources Department, XYZ Insurance Agency, etc.). In this example, Jane Doe has identified her daughter, Suzy Smith as the person who is authorized to receive her information.

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III. Specific Description of Information to be Used or Disclosed *(Please Complete **Parts A and B** in this Section)*

This Authorization CANNOT be used to disclose Psychotherapy Notes.

Section III will assist in determining what PHI the individual identified in Section I allows the receiving person/entity identified in Section II to receive. This section has two parts, both of which must be completed.

A. Release of Sensitive Protected Health Information Under State Law

You must check "yes" or "no" if you authorize the release of medical information, test results, records or communications specific to ***(note: "yes" means this information is included in the categories you designate in Part B below)*:**

- Human Immunodeficiency Virus (HIV) or HIV/Acquired Immune Deficiency Syndrome
- Sexually transmitted or "communicable" diseases (includes hepatitis, as well as venereal diseases);
- Drug, alcohol or substance abuse;
- Mental health or developmental disabilities (including mental retardation or similar disabilities, for example, those attributable to cerebral palsy, autism or neurological dysfunctions); and
- Genetic testing.

Yes ☒

No ☐

Section III A. asks if the authorizing individual identified in Section I wants the receiving person/entity identified in Section II to receive ***Sensitive*** Protected Health Information (SPHI). SPHI are certain types of health information for which various states' laws require extra protections. Either "**Yes**" or "**No**" must be chosen. In this example, Jane has agreed to let Suzy receive her SPHI.

B. Release of Protected Health Information *(check one or more)*

			Dates of Services From:	Dates of Services To:
☐	Health Plan Benefit Information:	Includes information contained in your benefit booklet (i.e., copayments, coinsurance, eligibility and other benefit information).	________	________
☒	Claims Information:	Includes information related to payment of your claims for service you received, including pertinent information located on a claim form (i.e., billed amount, general procedure descriptions claim payment or denial reasons, etc.).	6-12-05	4-30-08
☐	Service Determination Information:	Includes any information related to pre-service, concurrent and post-service decisions.	________	________
☐	Premium	Includes information related to billing cycles, bank draft changes, etc.	________	________
☐	Services from (provider or supplier):	Provider name: ______________________ (Includes information related to services rendered by a specific provider or supplier.)	________	________
☐	Other:	______________________ (Specify other information that is not listed in one of the categories above.)		

Section III B. asks for the specific types of information that the individual identified in Section I is authorizing BCBSTX to disclose to the person/entity identified in Section II. In this example, Jane is authorizing BCBSTX to provide her daughter with her claims information for the time period listed. "Dates of Service" means disclosing information for health care services the individual received during a particular time period. For example, in this case Jane Doe is authorizing BCBSTX to disclose claims information for health care services provided during June 12, 2005 through April 30, 2008.

IV. Expiration and Revocation:

Expiration: This authorization will expire on (must choose one):

☒ One year from the date it is signed ☐ Other (insert date or event): ______________________________

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. **I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.**

Section IV. asks for the "expiration" date and a statement regarding the individual's right to revoke. All valid authorizations must contain a specific expiration date or expiration event (e.g. "***hospitalization end date***", "***rehabilitation end date***", etc). In this example, the authorization will remain valid for a period of one year from the date it was signed, or until Jane revokes the authorization.

V. Signature (this document must be signed by the individual, parent of minor child or the individual's personal representative)**:**

I understand that this authorization is voluntary and that the health plan cannot condition my eligibility for benefits, treatment, enrollment or payment of claims on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

Jane Doe ______________________________ ***4-30-08*** ______________

Signature **Date: month/day/year**

If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator complete the following and attach a copy of the Legal documents. You do NOT have to attach copies of these documents if they are already on file with Blue Cross and Blue Shield of Texas:

______________________________ ______________________________

Personal Representative's Name **Relationship to Individual**

______________________________ ______________________ __________ __________

Personal Representative's Address **City** **State** **ZIP**

____

Personal Representative's Area Code & Telephone Number

Section V. requires the signature and date. In order to be valid, the authorization form must be signed by either the individual identified in Section I or the individual's personal representative identified in Section V. If the individual is a minor dependent under the age of 18, a parent or guardian may sign the authorization form. A personal representative has received legal authority to represent the individual. In this case, since Jane is completing the form, there is no need for a personal representative to sign. If Jane's personal representative were signing this authorization on her behalf, the personal representative must complete the lower portion of Section V and submit the proper documentation with the authorization form (if not already on file with BCBSTX).

BEFORE SENDING AUTHORIZATION FORM
YOU SHOULD KEEP A COPY FOR YOUR RECORDS
BY EITHER:

(1) MAKING A PHOTOCOPY OF THIS SIGNED AUTHORIZATION; OR
(2) COMPLETING AND SIGNING THE DUPLICATE AUTHORIZATION FORM YOU RECEIVED OR PRINTED

The final portion of the form contains some instructions to be followed prior to mailing the form to BCBSTX. Members are advised to keep a signed copy for their records.

BlueCross BlueShield of Texas

Standard Authorization Form To Use or Disclose Protected Health Information (PHI)

I. Individual (Name and information of person whose protected health information is being disclosed):

Name		Date of Birth
Group #	Identification/Subscriber #	Social Security Number
Address	City	State / ZIP
Area Code & Telephone Number		

II. Authorization and Purpose:

I request and authorize Blue Cross and Blue Shield of Texas to disclose my protected health information as described below. **I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.**

Persons/Organizations authorized to receive your information	Relationship	Purpose	
Address	City	State	ZIP

III. Specific Description of Information to be Used or Disclosed *(Please Complete **Parts A and B** in this Section)*

This Authorization CANNOT be used to disclose Psychotherapy Notes.

A. Release of Sensitive Protected Health Information Under State Law

You must check "yes" or "no" if you authorize the release of medical information, test results, records or communications specific to ***(note: "yes" means this information is included in the categories you designate in Part B below)*****:**

- Human Immunodeficiency Virus (HIV) or HIV/Acquired Immune Deficiency Syndrome
- Sexually transmitted or "communicable" diseases (includes hepatitis, as well as venereal diseases);
- Drug, alcohol or substance abuse;
- Mental health or developmental disabilities (including mental retardation or similar disabilities, for example, those attributable to cerebral palsy, autism or neurological dysfunctions); and
- Genetic testing.

Yes ☐

No ☐

B. Release of Protected Health Information *(check one or more)*

			Dates of Services From:	To:
☐	Health Plan Benefit Information:	Includes information contained in your benefit booklet (i.e., copayments, coinsurance, eligibility and other benefit information).	________	________
☐	Claims	Includes information related to payment of your claims for service you received, including pertinent information located on a claim form (i.e., billed amount, general procedure descriptions claim payment or denial reasons, etc.).	________	________
☐	Service Determination Information:	Includes any information related to pre-service, concurrent and post-service decisions.	________	________
☐	Premium	Includes information related to billing cycles, bank draft changes, etc.	________	________
☐	Services from (provider or supplier):	Provider name: ________ (Includes information related to services rendered by a specific provider or supplier.)	________	________

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☐ Other: ____

(Specify other information that is not listed in one of the categories above.)

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IV. Expiration and Revocation:

Expiration: This authorization will expire on (must choose one):

☐ One year from the date it is signed ☐ Other (insert date or event): ______________________________

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. **I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.**

V. Signature (this document must be signed by the individual, parent of minor child or the individual's personal representative):

I understand that this authorization is voluntary and that the health plan cannot condition my eligibility for benefits, treatment, enrollment or payment of claims on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

____ ____________________

Signature **Date: month/day/year**

If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator complete the following and attach a copy of the Legal documents. You do NOT have to attach copies of these documents if they are already on file with Blue Cross and Blue Shield of Texas:

____ ____________________

Personal Representative's Name **Relationship to Individual**

______________________________ ______________________________ __________ __________

Personal Representative's Address **City** **State** **ZIP**

____

Personal Representative's Area Code & Telephone Number

BEFORE RETURNING THIS FORM YOU SHOULD KEEP A COPY FOR YOUR RECORDS BY EITHER:

(3) MAKING A PHOTOCOPY OF THIS SIGNED AUTHORIZATION; OR
(4) COMPLETING THE DUPLICATE AUTHORIZATION FORM, YOU RECEIVED OR PRINTED

Mail your completed signed authorization to:
Blue Cross and Blue Shield of Texas
P.O. Box 660044
Dallas, TX 75266-0044

If you need assistance completing the form, please refer to the instructions above or contact the Customer Service number listed on the back of your Member Identification Card.

Any changes to the format, content or branding of this form are strictly prohibited without review and approval of the HCSC Privacy Office. Please contact the Privacy Office with any change requests.

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BlueCross BlueShield of Texas

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To speak to an interpreter, call the customer service number on the back of your member card. If you are not a member, or don’t have a card, call 855-710-6984.

العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث إلى مترجم فوري، اتصل على رقم خدمة العملاء المذكور على ظهر بطاقة عضويتك. فإن لم تكن عضوا، أو كنت ال تملك بطاقة، فاتصل على 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請致電印在您的會員卡背面的客戶服務電話號碼。如果您不是會員, 或沒有會員卡, 請致電 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d’aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, composez le numéro du service client indiqué au verso de votre carte de membre. Si vous n’êtes pas membre ou si vous n’avez pas de carte, veuillez composer le 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Kundenservicenummer auf der Rückseite Ihrer Mitgliedskarte an. Falls Sie kein Mitglied sind oder keine Mitgliedskarte besitzen, rufen Sie bitte 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી ર ા હોય એવી કોઈ બીજી યિક્તને એસ.બી.એમ. દુભાિષયા સાથે વાત કરવા માટે, તમારા સ યપદના કાડર્ની પાછળ આપેલ ગ્રાહક સેવા નબર પર કૉલ કરો. જો આપ સ યપદ ના ધરાવતા હોવ, અથવા આપની પાસે કાડર્ નથી તો 855-710-6984 નબર પર કૉલ કરો.
िहंदी Hindi	यिद आपके , या आप िजसकी सहायता कर रहे ह उसके , प्रæन ह, तो आपको अपनी भाषा म िनःशुãक सहायता और जानकारी प्राÜत करने का अिधकार है। िकसी अनुवादक से बात करने के िलए, अपने सद य काडर् के पीछे िदए गए ग्राहक सेवा नंबर पर कॉल कर। यिद आप सद य नहीं ह, या आपके पास काडर् नहीं है, तो 855-710-6984 पर कॉल कर।
日本語 Japanese	ご本人様、またはお客様の身の回りの方でも、ご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、メンバーカードの裏のカスタマーサービス番号までお電話ください。メンバーでない場合またはカードをお持ちでない場合は 855-710-6984 までお電話ください。
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 회원 카드 뒷면에 있는고객 서비스 번호로 전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984 으로 전화주십시오.
ພາສາລາວ Laotian	ຖ້າທ່ານ ຫຼື ຄນທີທ່ານກາລງໃຫ້ການຊ່ວຍເຫຼືອມຄີ ໆຖາມ, ທ່ານມສີ ິດຂໍເອົາການຊ່ວຍເຫຼືອ ແລະ ຂໍມູນເປັນພາສາຂອງທ່ານໄດ້ໂດຍບໍ່ມຄີ ່າ ໃຊ້ຈ່າຍ. ເພ່ ືອລມກບນາຍແປພາສາ, ໃຫ້ໂທຫາເບີຝ່າຍບໍລິການລູກຄ້າທ່ ີມຢີ ູ່ດ້ານຫງບດຂະມາຊິກຂອງທ່ານ. ຖ້າທ່ານບໍ່ແມ່ນສະມາຊກ, ຫຼື ບ່ໍມບີ ັດ, ໃຫ້ ໂທຫາເບີ 855-710-6984.
Diné Navajo	T’11 ni, 47 doodago [a’da b7k1 an1n7lwo’7g77, na’7d7[kidgo, ts’7d1 bee n1 ah00ti’i’ t’11 n77k’e n7k1 a’doolwo[. Ata’ halne’7 bich’8’ hadeesdzih n7n7zingo 47 kwe’4 da’7n7ishgi 1k1 an7daalwo’7g77 bich’8’ hod77lnih, bee n44h0zinii bine’d66’ bik11’. Koj7 atah naaltsoos n1 had7t’44g00 47 doodago bee n44h0zin7g77 1dingo koj8’ hod77lnih 855-710-6984**.**
فارسی Persian	شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطالعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با خدمات مشتری به شماره ای که در پشت کارت عضویت شما درج شده است تماس بگیرید. اگر عضو نیستید، یا کارت عضویت ندارید، با شماره 855-710-6984 تماس حاصل نمایید.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы поговорить с переводчиком, позвоните в отдел обслуживания клиентов по телефону, указанному на обратной стороне вашей карточки участника. Если вы не являетесь участником или у вас нет карточки, позвоните по телефону 855-710-6984.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete comuníquese con el número del Servicio al Cliente que figura en el reverso de su tarjeta de miembro. Si usted no es miembro o no posee una tarjeta, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa numero ng serbisyo para sa kustomer sa likod ng iyong kard ng miyembro. Kung ikaw ay hindi isang miyembro, o kaya ay walang kard, tumawag sa 855-710-6984.
اردو Urdu	گر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، کسٹمر سروس نمبر پر کال کریں جو آپ کے کارڈ کی پشت پر درج ہے۔ اگر آپ ممبر نہیں ہیں، یا آپ کے پاس کارڈ نہیں ہے تو، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị hoặc người mà quý vị giúp đỡ có bất kỳ câu hỏi nào, quý vị có quyền được hỗ trợ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, gọi số dịch vụ khách hàng nằm ở phía sau thẻ hội viên của quý vị. Nếu quý vị không phải là hội viên hoặc không có thẻ, gọi số 855-710-6984.

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

BCBSTX provides TDD/TYY services and language assistance for incoming callers for deaf, hard-of-hearing and speech-disabled members. Members can utilize their TeleTYpewriter (TTY) or Telecommunication Device (TDD) to access a teletype operator at 1-800-735-2989.